Finance and Government
Operations Committee
May 29, 2002
Agenda Item #9
Dedicated to the Health of the Whole Community

Santa Clara Valley Health & Hospital System

Administration
2200 Moorpark Avenue
San Jose, California 95128
Phone (408) 885-4030

May 22, 2002

To: Supervisor Pete McHugh, Chairperson
Supervisor James T. Beall, Vice-Chairperson
Finance and Government Operations Committee

Supervisor Liz Kniss, Chairperson
Supervisor Blanca Alvarado, Vice-Chairperson
Health and Hospital Committee

From: Robert Sillen
Executive Director, SCVHHS

Subject: Report Back on Valley Specialty Center Operating Costs and Revenues

On April 16, 2002, Supervisor McHugh requested a report back to the Board through the Finance and Government Operations (FGOC) and Health and Hospital (HHC) Committees on the operating costs and revenues of the Valley Specialty Center (VSC) (see Attachment A for analysis). The referral stated that "The Committees should receive the report at their next respective meetings when each considers bond financing of capital facility projects after the April 30 Board workshop."

On May 13, 2002, a report back was sent to HHC on the strategic context for facilities projects, including an update of the "Strategic Business Plans for Valley Medical Center in a Competitive Market Place" (Attachment B). The Strategic Business Plan update reaffirms the recommendation for the development of a specialty outpatient center on the VMC campus.

SUMMARY

The VSC project both increases the County's capacity to provide specialty services to its residents and has a significant positive financial impact on VMC. This project:

- Expands critically needed specialty resources to the entire community,
- Enables continued expansion of primary care clinics, and
- Without VSC, the VMC contribution margin falls to a negative $6.3 million in FY06. With VSC, the contribution margin (the difference between collected revenues and direct expenses) is a positive $8.6 million per year by FY06.

METHODOLOGY

The referral requested staff to provide an analysis that is modeled after the Milpitas and Gilroy report submitted to HHC on March 15, 2002. Therefore we reviewed the direct expenses and the resulting revenue associated with the operations of VSC. Direct expenses include Object 1 (all staffing costs), Object 2 (medical and office supplies, contract services, etc) and Ancillary expense (special procedures, pharmacy, radiology, and lab). We did not include the debt service of the building. Furthermore, the referral asked staff to perform the same analysis to project for patient visits at 171,500, 200,000 and 228,500. Staff did not perform the last visit option because VSC capacity is 200,000.

In order to accomplish the above, staff used FY01 as the base year for projection and included only those specialty services that will be housed in the VSC. The analysis captured all clinical and ancillary costs, outpatient visits and inpatient activity. In other words, everything that happened financially to these patients while at VMC was captured. However, if a patient was seen only in the inpatient setting they were excluded since the purpose of the analysis was to focus on VSC.

ANALYSIS

The following was reviewed to perform the analysis:

(1) The relationship between specialty clinic visits and inpatient volume,
(2) The payer mix over the past 5 years of specialty patients at VMC, and
(3) The costs and revenues associated with specialty care.

1. The relationship between specialty clinics visits and inpatient volume

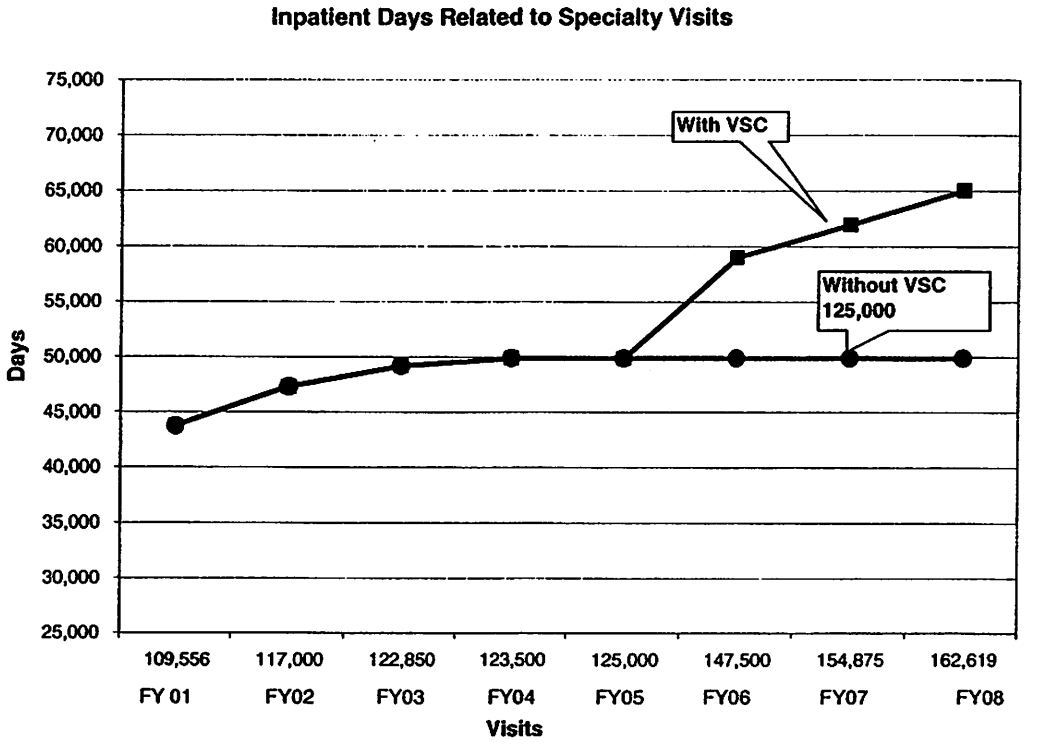
In FY01, 36,664 patients were seen by specialists that would be in VSC. These patients had 109,556 outpatient visits and 43,750 inpatient days. This is a ratio of 2.5 visits per inpatient day and approximately one admission for each five patients.

These ratios are critical. When specialty physicians approach capacity, the number of admissions to VMC by those specialists will no longer grow. This limits the growth of inpatient days at VMC. In the last five years, there has been increased specialty services and increased days at VMC. Five years ago, our specialists were using 78% of their exam rooms at any given time, now 95% of those exam rooms are used.

The following graph shows the impact of patient days at VMC under two scenarios:

Scenario A: VSC is not constructed.

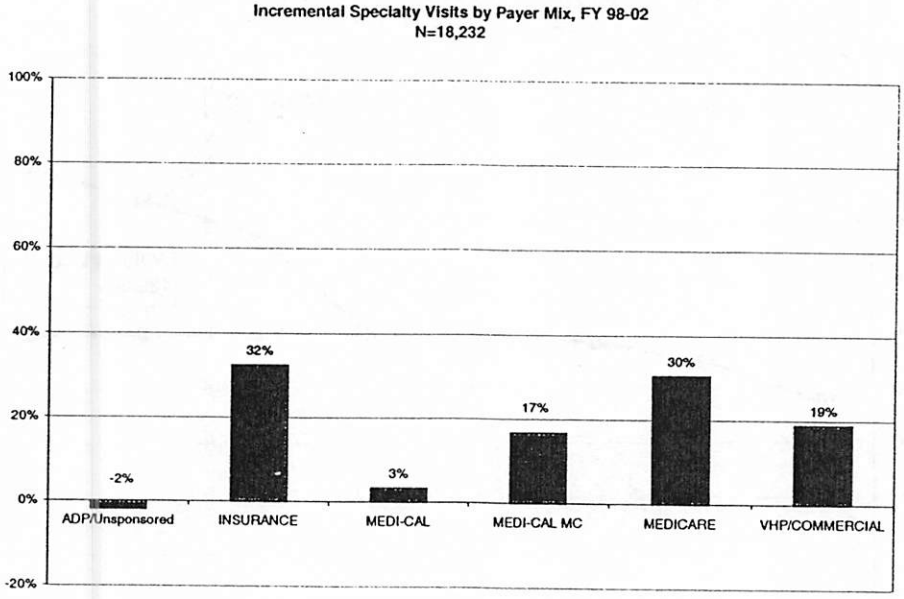
Scenario B: VSC is constructed with continued growth of inpatient days.



2. The payer mix over the past 5 years of specialty patients at VMC

Patient visits to specialty clinics relocating to VSC have increased by 18,238[1] over the last five years. ***100% of those visits were sponsored.*** This favorable change in payer mix is partly due to the new Main Hospital which attracted a higher number of sponsored patients.

[1] Previously submitted as 27,065 visits, less employee health and other specialty visits that occur at satellite clinics.



3. The costs and revenues associated with VSC

Given the relationship between outpatient visit volume and inpatient census and the payer mix of incremental outpatient visits over the last five years, we analyzed the financial implications for VMC of two scenarios. We use FY01 as the base year for all projections and FY06 for the fiscal analysis for both scenarios.

Scenario A – No VSC

What would be the financial implications to VMC of not building VSC? The assumption is that visits would stay at or near capacity and that inpatient referrals from those specialists would have little or no growth.

The following table illustrates the direct operating cost and collected revenue in FY01 compared to that of FY06 if VSC is not built.

	FY01	**FY06 Scenario A**
Outpatient Visits	109,556	125,000
Expenses (Obj 1, 2 & anc)		
Outpatient Direct	$22,568,536	$34,459,309
Inpatient Direct	$58,554,995	$89,397,153
TOTAL Direct Expenses	**$81,123,531**	**$123,856,462**
Collected Revenues		
Outpatient Visits	$15,649,322	$21,867,348
Inpatient Days	$68,782,505	$95,697,312
TOTAL Collected Revenues	**$84,431,827**	**$117,564,660**
Contribution Margin	**$3,308,296**	**($6,291,802)**

Scenario B – Build VSC

What would be the financial implications to VMC if we build VSC? The assumption is that visits and inpatient activity would continue to grow but would be slowed until the building is complete in the fall of 2005.

The following table shows the direct operating cost and collected revenue in FY01 compared to that of FY06. The referral asked us to look at three different visit levels for VSC: 171,500, 200,000, and 228,500. Since the capacity of VSC is estimated to be 200,000 visits we have not included the 228,500 option. However, we have added a level of 147,500 as a near-term scenario for FY06.

	FY01	**Scenario B FY06**		
Visits	109,556	147,500	171,500	200,000
Expenses (Obj 1, 2 & anc)				
Outpatient Direct	$22,568,536	$40,661,984	$47,278,171	$55,134,894
Inpatient Direct	$58,554,995	$110,986,403	$131,628,052	$156,140,011
TOTAL Direct Expenses	**$81,123,531**	**$151,648,388**	**$178,906,224**	**$211,274,905**
Collected Revenues				
Outpatient Visits	$15,649,322	$27,924,273	$33,464,235	$40,042,940
Inpatient Days	$68,782,505	$132,358,174	$163,025,129	$199,442,139
TOTAL Collected Revenues	**$84,431,827**	**$160,282,447**	**$196,489,365**	**$239,485,079**
Contribution Margin	**$3,308,296**	**$8,634,060**	**$17,583,141**	**$28,210,174**

Incremental Facilities Cost

On March 22, 2002 GSA reported to FGOC facilities costs by applying a generic allowance to the entire square feet of each new county building. At 234,000 square feet, VSC was estimated at $2.5 million. VMC estimates this cost to be considerably less.

Programs moving into VSC will vacate 121,000 square feet for a net increase of 113,000 square feet. Based on VMC's estimates of costs per square feet this would create an incremental facilities cost of $0.6 million. Therefore, a reasonable budget for facilities would be $1 million.

CONCLUSION

In these times of financial uncertainty, the County has an opportunity to proceed with a project, the Valley Specialty Center, that provides additional critical services to the community while maintaining the financial viability of VMC and the County.

ASSUMPTIONS for VSC Financial Analysis

Visits

*Defined by the different scenarios.

*Inpatient days are driven by outpatient visits and will vary by payer mix. FY01 is the base.

Payer Mix

*FY01 is the base.

*Using the past 5 years' experience, incremental specialty visits will be 38% Medicare; 4% Medi-Cal; 21% MCMC; 37% Insurance; and 0% for Unsponsored and VHP. This assumption is applied to FY03 and FY 06 Scenario B. Therefore, outpatient visit mix will show a growth in all payer source except unsponsored and VHP. Furthermore, since inpatient days are driven by outpatient visits, the inpatient payer mix will also change.

*The payer mix in FY01 is applied to all visits in FY 06 Scenario A.

Expenses

*Direct expenses increase by 6% each year.

*Capital, debt service, construction and building costs are excluded.

Revenue

*Medi-Cal increase 20% for FY02 (as result of lawsuit, the increase was 30% but 20% was used), then 3% thereafter.

*Medicare, MCMC, insurance and VHP increase by 3% annually.

*Unsponsored has no increase.

*Rate per visit or day is based on FY01 experience by payer mix.

ASSUMPTIONS for VSC Financial Analysis

Visits

*Defined by the different scenarios.

*Inpatient days are driven by outpatient visits and will vary by payer mix. FY01 is the base.

Payer Mix

*FY01 is the base.

*Using the past 5 years' experience, incremental specialty visits will be 38% Medicare; 4% Medi-Cal; 21% MCMC; 37% Insurance; and 0% for Unsponsored and VHP. This assumption is applied to FY03 and FY 06 Scenario B. Therefore, outpatient visit mix will show a growth in all payer source except unsponsored and VHP. Furthermore, since inpatient days are driven by outpatient visits, the inpatient payer mix will also change.

*The payer mix in FY01 is applied to all visits in FY 06 Scenario A.

Expenses

*Direct expenses increase by 6% each year.

*Capital, debt service, construction and building costs are excluded.

Revenue

*Medi-Cal increase 20% for FY02 (as result of lawsuit, the increase was 30% but 20% was used), then 3% thereafter.

*Medicare, MCMC, insurance and VHP increase by 3% annually.

*Unsponsored has no increase.

*Rate per visit or day is based on FY01 experience by payer mix.

Attachment A: VSC Financial Analysis

			FY06			
	FY 01	FY03 Budget	Scenario A (no VSC)	Scenario B		
Outpatient Visits	109,556	122,850	125,000	147,500	171,500	200,000
Inpatient Days assoc. w/visits	43,750	49,209	49,912	61,966	73,491	87,176
Outpatient Payer Mix						
Medicare	21%	23%	21%	27%	27%	29%
Medi-Cal	27%	25%	27%	20%	19%	17%
Medi-Cal MC	8%	9%	8%	12%	13%	14%
Insurance	10%	13%	10%	19%	20%	22%
Unsponsored	28%	25%	28%	18%	18%	15%
VHP	6%	5%	6%	4%	4%	3%
Inpatient Payer Mix						
Medicare	17%	18%	17%	20%	21%	21%
Medi-Cal	42%	38%	42%	28%	27%	24%
Medi-Cal MC	5%	6%	5%	7%	7%	8%
Insurance	19%	24%	19%	34%	35%	39%
Unsponsored	15%	13%	15%	9%	9%	7%
VHP	1%	1%	1%	1%	1%	1%
Expenses(Obj 1, 2 & anc)						
Outpatient Direct	$ 22,568,536	$ 28,435,058	$ 34,459,309	$ 40,661,984	$ 47,278,171	$ 55,134,894
Inpatient Direct	$ 58,554,995	$ 74,001,779	$ 89,397,153	$ 110,986,403	$ 131,628,052	$ 156,140,011
TOTAL DIRECT EXPENSES	**$ 81,123,531**	**$ 102,436,837**	**$ 123,856,462**	**$ 151,648,388**	**$ 178,906,224**	**$ 211,274,905**
Collected Revenue						
Outpatient Visits	$ 15,649,322	$ 19,711,607	$ 21,867,348	$ 27,924,273	$ 33,464,235	$ 40,042,940
Inpatient Days	$ 68,782,505	$ 86,362,263	$ 95,697,312	$ 132,358,174	$ 163,025,129	$ 199,442,139
TOTAL PATIENT REVENUE	**$ 84,431,827**	**$ 106,073,871**	**$ 117,564,660**	**$ 160,282,447**	**$ 196,489,365**	**$ 239,485,079**
CONTRIBUTION MARGIN	**$ 3,308,296**	**$ 3,637,034**	**$ (6,291,802)**	**$ 8,634,060**	**$ 17,583,141**	**$ 28,210,174**

Attachment B

STRATEGIC BUSINESS PLANS FOR VALLEY MEDICAL CENTER IN A COMPETITIVE MARKET PLACE

Update 2002: Report for Health and Hospital Committee Meeting, May 23, 2002

This report reviews Valley Medical Center's progress since the May 2, 2000 adoption by the Board of Supervisors of VMC's Strategic Business Plans (SBP 2000) to improve its position in the Santa Clara market for healthcare services. The goal of SBP 2000 was to focus VMC's efforts to better achieve its "open door" mission by meeting the challenges of market competition for sponsored patients.

The May 2000 Strategic Business Plans:

- identified trends facing all hospitals nationwide and public hospitals in particular – trends that create a dilemma for public hospitals;
- developed a framework for analysis and strategy development toward payers, geographic areas, and partners; and
- recommended strategic actions to:
  - maximize the benefit of managed care relationships;
  - build relationships with community physicians;
  - expand VMC's presence in underserved areas;
  - expand enrollment and sponsorship; and
  - improve County understanding and practices to promote business plan success.

Over the last two years, VMC has made great progress toward its objectives in each of these areas. In concert with others, it has actively expanded sponsored enrollment throughout the County, especially among children. Through managed care and other contracts, it has increased its insured patient volumes and overall patient census significantly and thereby moderated the net county cost of its programs. It is expanding its community ambulatory capacity along with its rapid growth of inpatient census. VMC's progress is a strong argument for the soundness of the strategies the Board adopted in May 2000; however, several recent trends suggest some "mid-course" adjustments in management's priorities. In particular, VMC's success over the last two years has strained the system and showed more clearly than two years ago the importance of

additional capacity, especially facilities for ambulatory specialty care. Valley Specialty Center is a most critical next step; its authorization will allow VMC to continue the progress it has made; delay or cancellation could reverse many of the Health and Hospital System's recent gains.

The 2000 Strategic Business Plans

What did SBP 2000 research conclude about VMC's situation and areas for its strategic focus? The following is a summary of the Plans' important conclusions and comments about their relevance to today's questions.

SBP 2000 Problem: The Dilemma Facing Public Hospitals

Public hospitals throughout the nation face a dilemma of rising mission imperatives on the one hand versus declining federal and state resources to support them on the other hand. They must continue to meet their mission imperatives as the "open door" providers in their communities at a time when increasing numbers and proportions of the nation's residents lack health insurance, welfare reform has reduced the Medicaid rolls, and the federal and state governments are looking to reduce payments to all hospitals to pay for higher costs of drugs and other patient care services. The special funds that have preserved the safety net over the last two decades are at risk. These marketplace trends create financial difficulty for most hospitals. As a result, public hospitals face intensified competition for sponsored patients, but no competition for the uninsured. To keep their doors open, public hospitals must meet market imperatives and compete for sponsored patients. As government institutions, they face barriers to achieving more efficient operations that other hospitals do not face.

Santa Clara County long has been one of the most difficult markets for health care providers in the country. For VMC, the public hospital dilemma is particularly acute. VMC faces competition from established regional/national hospital systems that have relationships with established medical groups and managed care plans covering high proportions of the area's residents. Private hospitals can pull back to services that are profitable regardless of community need; the plans announced by Tenet and HCA show just this strategy. Some private physicians have ended their Medicare managed care contracts and many others are considering reducing their involvement with publicly financed patient care. Private hospitals do not intend to replace their physical facilities and expand their services in line with the expected growth and aging of Santa Clara's

population. This will continue to increase the hospitals' abilities to negotiate higher rates from managed care companies, but at the risk that any set of factors that increase the demand for care – a flu epidemic, bioterrorism, or an earthquake, for example – will overwhelm the County's health care system. VMC's doors, in contrast, must be open to the entire community. These trends will make VMC's emergency services, inpatient beds and ambulatory services – especially those in referral specialties – even more important to Santa Clara's residents in the future.

The dilemma facing public hospitals can be mitigated by strategies aimed at maximizing the use of the public hospital's facilities and minimizing operating costs. Most important are focused approaches for maintaining and expanding their historical Medicaid populations. In VMC's growing market, the Hospital has been able to use its delegated contracting authority to expand significantly its private contract business with managed care plans. VMC has been successful in increasing its patient volumes and market share, especially in increasing its numbers of Medicare and Insurance patient days. VMC's new Main Hospital facility and highly competent, motivated medical staff have provided a solid basis for further success.

Cost control also is important for public hospitals, not only for mitigating the growth in the public subsidy for public patients, but also for the hospital's ability to offer prices to managed care plans that will attract private patients as well. Seeking efficiency brings together the imperative of market competition with the imperative of public stewardship to assure open door access. Operating flexibility delegated by the Board of Supervisors will remain critical to VMC's ability to control its costs.

SBP 2000 plan identified six overall conclusions from its review of VMC's mission, the Santa Clara market, and the strategies of highly successful public hospitals:

1. VMC must be able to compete in the health care marketplace -- meet the market's imperatives -- if it is to succeed in meeting its mission imperatives.
2. VMC should expand and improve the "gateways" to its services on-campus, replacing VMC's outpatient department (OPD) with a building built to medical group practice standards, and off-campus, expanding ambulatory care in specific areas that are underserved but also have a mix of sponsored patients.

3. Several types of partnerships have high potential for attracting sponsored patients who would use existing VMC resources. In particular, VMC should seek to expand partnerships with managed care plans and community physicians.
4. VMC managers and medical staff leaders have limited time and resources for new initiatives, so focus and triage are important.
5. The market is rapidly changing; managers need freedom within a framework to be able to seize opportunities and take risks responsibly.
6. The Supervisors and the political tradition in Santa Clara County have a preference for expansion of access to needed services in the community and making the best use of the assets they have put into place, rather than cutbacks or outsourcing that could compromise County programs, employment, and finances.

SBP 2000 Framework: Where Should VMC Focus its Efforts?

The Strategic Business Plans recommended that VMC should focus its efforts to improve its mission achievement and market position in three areas: payers, geographic areas, and partners:

- Payers. VMC's inpatient contribution margins (net revenues in excess of variable costs) from all payers are positive: net county costs are reduced by the addition of any additional inpatients, other than unsponsored ones. SBP 2000 recommended that VMC should focus on expanding public program enrollment and developing relationships with private managed care plans to slow the growth in net county cost.
- Geographic Areas. SBP 2000 recommended that VMC should find opportunities to expand geographically in areas with mixed sponsored and unsponsored patients, especially those with high growth in population, high concentrations of Medi-Cal beneficiaries, and relatively low VMC Medi-Cal market share. These regions included Franklin-McKinley, Central San Jose/VMC Campus, and South County. Two other areas which currently lack VMC presence, Milpitas-Berryessa, with its high numbers of Medi-Cal eligibles and Santa Clara/VMC campus also were identified as areas for potential ambulatory care expansion. Downtown San Jose warrants special focus in light of HCA's evolving plans for the San Jose Medical Center campus.
- Partnerships. SBP 2000 recommended that VMC should seek partners who share VMC's values and can bring patients to VMC who will use resources that now are available (where marginal costs are low) and/or provide resources needed by VMC patients where VMC would incur high costs of providing the services directly. Partnerships with community physicians and with managed care plans (such as Lifeguard) in particular can be used to bring focused groups of patients to VMC, or to enable VMC to expand its services geographically. VMC should continue to take a broad approach to partnerships, in line with its mission as the County's open door provider.

Strategic Actions: SBP 2000 Recommendations and 2002 Update

SBP 2000 recommended that VMC should take a number of actions over the next three years in the following five areas, to make best use of VMC for the public benefit:

1. Maximizing the benefit of managed care relationships.
2. Building relationships with community physicians
3. Expanding VMC presence in underserved areas
4. Expanding enrollment and sponsorship
5. Improving County understanding and practices to promote business plan success

What should VMC's priorities be in each of these areas today, and what are the critical issues for the next several years? Following a discussion of emerging trends since 2000, VMC's progress and remaining challenges in each of these areas are discussed.

Emerging Trends

Since 2000, four trends have emerged that were not fully visible in SBP 2000, each of which is important to VMC's ability to continue to achieve the goals set in SBP 2000 and continue to achieve its mission in a highly competitive environment:

- The 2000 Census showed that Santa Clara County's population continues to grow and age, and at faster rates than projected in SBP 2000. The Census numbers on births and immigration in particular led the Association of Bay Area Governments to increase its projections of future population for the County. Over the next 30 years, Santa Clara's population is expected to grow by nearly one-third to 2.2 million, an addition of more than 525,000 people. While Santa Clara will remain younger than other Bay Area counties, the growth in its number of elders will significantly increase the need for ambulatory and inpatient specialty medical services, especially those focusing on chronic illness. Specialists such as cardiologists and oncologists frequently are the primary care providers for elders. Continued active utilization controls, the development of ambulatory care modalities, and VMC's hospitalist program for inpatient physician care have had the result that essentially all admissions are now for specialty care.
- The 9-11 and anthrax terrorist attacks showed clearly the vulnerability of our society and underscored the need for reserve capacity in the health care system, especially in specialized services closely linked to public health. All health care institutions and providers share this responsibility, but it falls disproportionately on VMC, as the county's open door provider and the primary partner of the County's Public Health Department in the Santa Clara Valley Health and Hospital System.
- The varieties of trends affecting individuals' choices of careers have created extreme difficulties in recruiting and retaining a highly qualified healthcare workforce. This puts a premium not only on wages and benefits but also working environments, including physical facilities designed to maximize the efficiency of staff efforts and promote the development of leading services that will give staff a sense of mission achievement.
- Other providers are responding to these trends with focused strategies and targeted expansion. Private hospitals' plans to rebuild their facilities to meet the timelines for seismic

safety improvements required by SB1953 include modest inpatient expansions – less than the growth in population would suggest – and focus on profitable services. Providers nationwide and in Santa Clara are exiting from Medicare and Medicaid managed care arrangements, and some are refusing to take on additional publicly insured patients. Especially for its unsponsored patients, but increasingly for Medicaid patients as well, access will depend on VMC having its own skilled employed workforce. At the same time, ambulatory care providers such as the Palo Alto Medical Group, San Jose Medical Group and Camino Medical Group have invested heavily in state-of-the-art, attractive clinic space for specialty and primary care services. This has "raised the bar" for VMC, and made the contrast with VMC's circa 1950 OPD building on campus even more striking. This is a significant disadvantage to VMC's ability to offer services acceptable to all the residents of the county, especially insured patients.

Taken together, these trends underscore the continued importance of physical facility development to VMC's ability to meet both its mission and its market imperatives.

SBP 2000 Recommendations, VMC Progress, and Update

1. Maximizing the Benefit of Managed Care Relationships

SBP 2000 recommended that VMC should:

- Continue to seek contracts to provide specialty services to persons enrolled with private managed care plans, meeting regularly and seeking opportunities with the largest MCOs in the area, negotiating especially about services where VMC has capacity, and reporting progress to the HHC and BOS at six-month intervals;
- Continue its strategy of seeking a broad set of relationships, creating breadth and multiple opportunities with managed care organizations;
- Review the economic performance of each existing agreement, focusing especially on payment rates for VMC's unique services and negotiating clauses to improve payment terms and constrain VMC's risks;
- Maintain its policy of rejecting new proposals that fail to meet economic thresholds or would require expansion of capacity, unless expansion also benefits VMC's mission patients;
- Seek a primary care relationship with one or more plans; and
- Regularly assess service delivery performance, patient satisfaction, enrollee retention, and economic benefit.

Progress. VMC has moved forward with contracts with Lifeguard and Kaiser that have opened the door for significant private insurance business. These contracts have built VMC inpatient volumes and provided flows of funds that have reduced net county costs. Since 1999, VMC's insurance patient days are up nearly 45% and admissions by nearly 90%. VMC's overall

inpatient census has increased significantly since the opening of the new Main Hospital. Now it is running five percent above this year's increased budget projections. Managed care contracts have increased the use of VMC's ambulatory specialty services, in part because VMC is the only specialty provider to which Lifeguard's primary care physicians can refer patients without prior plan approval. VMC's insurance patient visits are up by 55% since 1999, an increase of nearly 48,000 visits, most of them for specialty care. A higher percent of them are leading to inpatient admissions. Changing market dynamics and effective contracting strategies also have improved the economics of VMC's contracts. Private managed care plans see VMC as a referral provider of specialty services, which complements the referral volumes from VMC's own ambulatory primary care operations and community clinics in the neighborhoods.

Update 2002. VMC should continue its successful strategies with managed care organizations, including Santa Clara Family Health Plan and VHP, to keep its door open to these sponsored patients and produce scale economies of benefit to all its operations. As discussed further below, VMC's challenge now is to continue to improve its facilities and systems, to make sure that patients' and referring physicians' experiences are favorable, so they will continue to request access to VMC.

2. Building Relationships with Community Physicians

SBP 2000 recommended that VMC should:

- Assess VMC/ACHS services with available physical capacity and/or tight MD capacity;
- Through VMC medical staff leaders, seek agreements with community physicians in the desired specialties, assessing additional patient volumes, payer mix and additional VMC staff needed to handle the patients under each potential agreement;
- Leverage expanded physician relationships obtained though Lifeguard to encourage inpatient specialty referrals;
- Investigate private physician interest in space in the office building (Valley Specialty Center) that will replace VMC's existing OPD;
- Off-campus, test co-location with community physicians as a way to expand primary care in one area in which ACHS under-serves the community; and
- Continue to work with VMC's existing FQHC partners, exploring especially their interest in additional locations.

Progress. Since 2000, VMC's contracts with Lifeguard and SCFHP, through which VMC provides referral ambulatory and inpatient services for private primary care physicians, have increased the familiarity of private physicians with VMC physicians and services. This has been critical to the development of sponsored patient volumes at VMC. VMC's contract with Kaiser has made effective use of interventional cardiology capacity that VMC otherwise would not have filled. Contracts with individual physicians have provided capacity in services at the levels that VMC has needed. On the other hand, VMC's experience since 2000 has been that development of agreements with private physicians takes time and management resources, and may not produce results even if a first assessment suggests that there is a commonality of interest on which to base a relationship. Several physician partnerships that initially looked favorable have fallen through, and in other situations VMC has sought partners in communities it has targeted for expanding access, but not been able to find them. Finding partners willing to help meet VMC's mission toward unsponsored and Medi-Cal patients is increasingly challenging. Further, in order to negotiate effectively, VMC needs resources (for example, space, operating room time) that the other party desires. As capacity throughout the VMC system has become more fully utilized, these resources are in short supply to meet VMC's missions.

These positive and negative experiences over the last two years can help focus VMC's future efforts to expand access.

Update 2002. VMC should continue to maximize the value of its relationships with managed care plans. VMC should take a more reserved posture than recommended in SBP 2000 toward partnerships with private physicians – one of "enlightened opportunism," rather than "active prospecting." VMC should make sure that it has the information and analytic framework to be able to respond to physician requests quickly with a strong understanding of the consequences of the particular "deal" being proposed, but not invest management time in seeking out private physician partners unless absolutely needed to meet VMC service requirements. VMC needs to set the capacity of its own ambulatory facilities on campus and in local communities based on the needs of its patients and the physicians fully in the County system. In light of trends in provider willingness to take on publicly funded patients, VMC should carefully and regularly

assess its own capacity and continue to focus on providing access through its own facilities and medical staff and its longstanding FQHC partners.

3. Expanding VMC Presence in Underserved Areas

SBP 2000 recommended that VMC should:

- Build the Franklin-McKinley project now in design.
- Replace VMC's on-campus outpatient department, which is a critical front door for VMC inpatient services, with a medical office building (Valley Specialty Center) of a quality consistent with the new Main Hospital.
- Plan a regional service strategy for the rapidly growing South County region, where hospital consolidation has reduced inpatient capacity and raised issues of access to reproductive health services.
- Explore options for expansion in Downtown San Jose in light of Columbia's anticipated service reductions on the SJMC Campus; and
- Explore partnerships for providing VMC services in the Milpitas-Berryessa and/or Santa Clara regions, where VMC currently has no presence.

Progress. Development of physical facilities for ambulatory care – the gateways to all VMC services – now is the most significant challenge facing VMC. Its success in contracting with managed care plans and expansion of enrollment in public insurance plans has created capacity bottlenecks that threaten to reverse VMC's progress. VMC facilities in the neighborhoods are reaching their capacity limits and most of the specialty services on campus are oversubscribed.

VMC is about to begin construction on the Franklin-McKinley center. It has developed initial plans for expansion of primary care services at Fair Oaks and in Milpitas and Gilroy, and begun investigation of service expansion elsewhere in the County as well. Changing market dynamics, as discussed above, make it likely that these will need to be VMC projects, rather than accomplished through partnerships. The Valley Specialty Center (VSC) project is in design development and bond financing is needed for construction.

The VSC project, including demolition of the existing OPD building, is the lynchpin for development of the VMC ambulatory care system countywide and also for the critical facilities projects on campus that are required by SB1953 in order to mitigate seismic risk and replace

obsolete buildings. The current OPD building that houses VMC's outpatient specialty services is the least up-to-date part of the whole VMC system. It is unattractive and unsuitable for the needs of patients and providers, especially in comparison with the new ambulatory specialty facilities of Palo Alto, Camino and San Jose Medical Groups. The growth and aging of the population in Santa Clara County will increase the need for ambulatory specialty services, especially those for cancer, heart disease, diabetes, and other chronic conditions of the elderly. To meet these needs cost-effectively, facilities for physician specialists need to be close to the expensive ancillary services (e.g., radiation therapy and infusion facilities, cardiac diagnostic and treatment equipment) they use; the specialized nursing and technical personnel the services require; and the hospital, where the specialists manage the care for relatively large numbers of inpatients. From this base, they can provide consultative help and backup for primary care physicians in the community. If patient volumes warrant it, specialists also can "circuit ride" to offer directly in the community clinics selected services that do not need expensive specialized equipment and care teams.

Update 2002. VMC should set its highest priority on development of the Valley Specialty Center, which is the lynchpin for system development countywide and on campus. It is the most important gateway to VMC's inpatient services (more than 45% of admissions), and will provide needed reserve capacity for Santa Clara County's public health response to any disaster scenario. If the specialty referral services planned for the VSC are not available, any growth in primary care services, including through the planned expansion in the neighborhoods, will only increase wait lists and beneficiary dissatisfaction, which will threaten VMC's progress and continued referrals by managed care plans. Not moving forward with VSC also would seriously compromise VMC's ongoing efforts to mitigate seismic risk and county liability concerns.

As discussed above, expansion of ambulatory primary care services in the neighborhoods also is important to VMC's mission achievement, and VMC should set high priority on the plans for Fair Oaks, Milpitas and Gilroy. VMC should monitor developments in downtown San Jose and for now continue to service the region through its existing facilities.

4. Expanding Enrollment and Sponsorship

SBP 2000 recommended that VMC should:

- Involve SSA in plans for new sites in underserved areas, to assure maximum opportunity for expansion of enrollment. This should include assuring adequate space is provided for SSA eligibility staff and seeking SSA information on potential eligibles as one input for deciding expansion locations.
- Provide space in Administrative Office Building 2 (AOB2) for an SSA district office on VMC campus and space for Council on Aging to develop fuller continuum of services for older adults;
- Continue planning to combine funding streams in an integrated program of medical and social services for elders, completing the program planning underway with Council on Aging and On-Lok and securing the needed waivers;
- Deepen its effort to enroll all who are eligible for existing public insurance programs;
- Participate in private and public efforts to expand sponsorship, working with FHP and VHP to maximize Healthy Families enrollment related to VMC; working with VHP to design products for individuals, small groups, and others; and working with a variety of partners to develop and market insurance products for small businesses; and
- Seek alternatives for funding demonstrations, continuing to actively monitor developments at the federal and state level to remain at the cutting edge of program development and seeking new partners among the community foundations and other philanthropies in Silicon Valley for developing demonstrations of funding approaches for the uninsured.

Progress. The County's investment in outreach workers to expand enrollment in Medi-Cal and Healthy Families has been extraordinarily successful, and the development with Working Partnerships, P.A.C.T., and Family Health Plan of the Healthy Kids insurance program has been a model for the nation. Since January 2002, Medi-Cal enrollment in the County is up by 18%, Healthy Families enrollment has more than doubled, and the Healthy Kids program has enrolled nearly 8000 children. Most come to VMC and its community clinics, where enrollment in these public managed care programs is up by nearly 80%. These programs have demonstrated the ability of new ideas in Santa Clara County to attract private philanthropic funds. Initial planning for AOB2 has occurred. On the other hand, since 2000 many counties, including Santa Clara have moved away from the AB1040 framework for integrated funding for care for elders, focusing instead on integrating services and information for improved care management.

Update 2002. VMC should continue its active involvement in efforts to increase enrollment and sponsorship, through the expanding Healthy Kids program and other outreach activities and

encouraging development of web-based and other convenient mechanisms for assuring that those who are eligible for benefits get them. Additional efforts in this regard likely should be focused on elders; other counties with significant immigrant populations have found that sizeable numbers who are eligible for Medicare may not have enrolled.

5. Improving County Understanding and Practices to Promote Business Plan Success

SBP 2000 recommended that Santa Clara County should:

- Continue the Board's longstanding support for VMC's strategy of achieving its public mission by providing market-competitive services for sponsored and unsponsored patients;
- More fully explore the potential for reducing its employee benefit costs though use of VMC as a cost-effective provider, considering incentives for County employees to choose insurance options that focus care at VMC and its ambulatory care sites;
- Expand VMC's existing delegated authority to other types of agreements, especially contracts with physicians and other arrangements to expand VMC capacity or provide services flexibly and cost-effectively; and
- Review the practices of County departments on which VMC relies for services, to assure that they promote VMC's ability to compete in the healthcare marketplace, where VMC is judged by its ability to conform to the business standards of the healthcare industry.

Progress. VMC's success over the last two years has been due in large part to the County's endorsement of VMC's overall strategy of achieving its public mission by providing market-competitive services for sponsored and unsponsored patients. VMC's contracting success has shown the value of delegated contracting authority for the system. The number of managed care contracts has increased, and they have provided greater economic value, reducing the growth in net county costs. Since 2000 also, the establishment of a County Counsel satellite office at VMC has smoothed workload and improved progress on joint tasks.

Update 2002. Continued Board support of VMC's overall strategy is critical to its success. County bond authority for development of the Valley Specialty Center, which is the lynchpin for system development countywide and mitigation of seismic risk on the VMC campus, is the most critical near-term need. It is the most important gateway to VMC's inpatient services, a crucial support for the activities of primary care practitioners in VMC and community clinics, and will provide needed reserve capacity for any disaster scenario.

Conclusions

VMC has opportunities to continue to better achieve its mission and improve its financial performance through focusing its program development on particular payers, in particular geographic areas, and with partners. Expansion of VMC specialty services through the Valley Specialty Center project will help increase enrollment and sponsorship, better enabling VMC to meet its mission imperatives, support the expansion of primary care access in the neighborhoods, and draw federal and state dollars to help mitigate the growth of net county cost. Without this building, the system as a whole will remain capacity-constrained, which will erode its recent gains.

VMC will continue to need operating flexibility and support from the County to take advantage of opportunities as they arise, as well as investment funds for the near term and ongoing costs of these initiatives. Capitalizing on these opportunities will take concerted action by the Board of Supervisors, County Administration, and VMC's leadership, medical and other staff. Through them, VMC can maintain its position as one of the nation's premier public hospitals, achieving its public mission by succeeding in the competitive healthcare marketplace.